

**STATE HEALTH BENEFIT PLAN
FY 2005 Open Enrollment
Request for Provider Directories**

Payroll Name: _____

Payroll #: _____

Shipping Street _____

Shipping City, State and Zip: _____

Contact Name and Phone #: _____

<u>Vendor</u>	<u>Quantity</u>
BlueChoice	_____
United Healthcare	_____
CIGNA	_____
Kaiser	_____
PPO	_____

DEADLINE TO REQUEST DIRECTORIES: JANUARY 23, 2004.
Fax this request to (404) 656-6405 or e-mail to jvinson@dch.state.ga.us